Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NORTH TEXAS REHABILITATION CENTER

Respondent Name
ARCH INSURANCE CO

MFDR Tracking Number
M4-15-1943-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...there was an extent of injury and a Contested Case Hearing was held on [injured employee] prevail on his lumbar disc being part of his injury. Please rule carrier must pay for our services."

Amount in Dispute: $6,300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Additional payment in the amount of $1,282.50 was issued on 4/8/2015. Attached is a copy of the EOR and payment screen."

Response Submitted by: ACE ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 25, 2014, February 26, 2014, February 27, 2014 and February 28, 2014	97799-MR-CA	$6,300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the Medical Fee Guideline for Workers' Compensation Specific Services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 216 – Based on the findings of a review organization.

Issues

1. Did the requestor withdraw from review dates of service February 27, 2014 and February 28, 2014?
2. Did the insurance carrier issue payment for the disputed services rendered on February 25, 2014 and February 26, 2014?

Findings

1. Review of correspondence between the Division and Art Gonzales, dated March 24, 2015 states in relevant part, "...you can take 2/27 and 2/28 out..." As a result and at the Requestors request, dates of service February 27, 2014 and February 28, 2014 were not included in this review.
2. Per 28 Texas Administrative Code §134.204 "(h) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier. (4) The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "MR" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $90 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   The requestor seeks reimbursement in the amount of $3,150.00 for dates of service February 25, 2014 and February 26, 2014. Review of the supplemental documentation (Explanation of Benefits) submitted by the insurance carrier supports that payment in the amount of $1,282.50 was issued on April 8, 2015 for dates of service February 25, 2014 and February 26, 2014, under draft number FE4824XXXX.

   The requestor seeks 6 hours of Outpatient Medical Rehabilitation Programs for date of service February 25, 2014. The MAR reimbursement for a CARF accredited Outpatient Medical Rehabilitation Programs is $90.00/hour x 6 hours = $540.00. The insurance carrier paid $562.50; as a result, no additional payment is due.

   The Requestor seeks 8 hours of Outpatient Medical Rehabilitation Programs for date of service February 26, 2014. The MAR reimbursement for a CARF accredited Outpatient Medical Rehabilitation Programs is $90.00/hour x 8 hours = $720.00. The insurance carrier paid $720.00; as a result, no additional payment is due.

   Review of the submitted documentation finds that the insurance carrier issued payment for the disputed services, as a result no further reimbursement is recommended for CPT code 97799-MR-CA rendered on February 25, 2014 and February 26, 2014.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 1, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).